

# State Copy

Health Financial Systems

HILLSBORO AREA HOSPITAL

In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED  
OMB NO. 0938-0050  
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1332	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/15/2018 9:37 am
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<b>PART I - COST REPORT STATUS</b>			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/15/2018	Time: 9:37 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**  
 MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HILLSBORO AREA HOSPITAL ( 14-1332 ) for the cost reporting period beginning 07/01/2017 and ending 06/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

**Encrypt on Information**

**ECR:** Date: 11/15/2018 Time: 9:37 am  
 QmPmSQDc7Np2XSexoS6gTuaHE: JSFO  
 cYHWDQUDxNnzHYLeN0wl zxWtbWMFU  
 lHyL0i Px030mU2l .

**PI:** Date: 11/15/2018 Time: 9:37 am  
 3aNq1fctSu: erX7ZQepBwMu1aBdt90  
 zE2tJOab. DKEavN29NwryPB3AQ6K6N  
 7. Gz0xdXTP07hlRS

(Signed) \_\_\_\_\_

Officer or Administrator of Provider(s)

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

	Title V	Title XVIII		HIT	Title XIX		
		Part A	Part B				
		1.00	2.00				3.00
<b>PART III - SETTLEMENT SUMMARY</b>							
1.00	Hospital	0	-20,311	-401,632	0	-73	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-59,851	0		0	5.00
6.00	Swing bed - NF	0	0	0		0	6.00
200.00	Total	0	-80,162	-401,632	0	-73	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1332		Period: From 07/01/2017 To 06/30/2018		Worksheet S-2 Part I Date/Time Prepared: 11/15/2018 9:35 am				
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1200 E. TREMONT	PO Box:							1.00	
2.00	City: HILLSBORO	State: IL		Zip Code: 62049		County: MONTGOMERY			2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
		V	XVIII	XIX						
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	HI LLSBORO AREA HOSPITAL	141332	99914	1	09/06/1975	N	0	0	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	HI LLSBORO AREA HOSPITAL	14Z332	99914		04/01/2004	N	0	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FOHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
17.20	Hospital-Based (OPT) I									17.20
17.30	Hospital-Based (OOT) I									17.30
17.40	Hospital-Based (OSP) I									17.40
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2017	06/30/2018		20.00	
21.00	Type of Control (see instructions)					2			21.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					N	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						2	N		23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0		24.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1332			Period: From 07/01/2017 To 06/30/2018		Worksheet S-2 Part I Date/Time Prepared: 11/15/2018 9:35 am		
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0			25.00
						Urban/Rural	S Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)					N			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N		40.00
						V	XVII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
						NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
						1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)					N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet S-2  
Part I  
Date/Time Prepared:  
11/15/2018 9:35 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
						1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1332		Period: From 07/01/2017 To 06/30/2018		Worksheet S-2 Part I Date/Time Prepared: 11/15/2018 9:35 am	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	3.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
				1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00

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			1.00	2.00	3.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
<b>Long Term Care Hospital PPS</b>					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00
<b>TEFRA Providers</b>					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00
			V	XIX	
			1.00	2.00	
<b>Title V and XIX Services</b>					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.06
<b>Rural Providers</b>					
105.00	Does this hospital qualify as a CAH?		Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		Y		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1332		Period: From 07/01/2017 To 06/30/2018		Worksheet S-2 Part I Date/Time Prepared: 11/15/2018 9:35 am		
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00			
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N		109.00	
					1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N			110.00
					1.00			
					2.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.				N			111.00
					1.00			
					2.00			
					3.00			
<b>Miscellaneous Cost Reporting Information</b>								
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.				N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.				N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.				Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.				1			118.00
		Premiums		Losses		Insurance		
		1.00		2.00		3.00		
118.01	List amounts of malpractice premiums and paid losses:	67,898		0		0		118.01
						1.00		
						2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.				N			118.02
DO NOT USE THIS LINE								
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.				N		N	119.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.				N			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.				Y		5.01	122.00
<b>Transplant Center Information</b>								
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.				N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.							134.00
All Providers								

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1332		Period: From 07/01/2017 To 06/30/2018		Worksheet S-2 Part I Date/Time Prepared: 11/15/2018 9:35 am	
		1.00		2.00			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y				140.00	
		1.00		2.00		3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y				144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y		01/21/2018		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					146.00	
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	Y				147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N				148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	Y				149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	Y		Y		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC			N		N	
161.10	CORF			N		N	
161.20	OUTPATIENT PHYSICAL THERAPY			N		N	
161.30	OUTPATIENT OCCUPATIONAL THERAPY			N		N	
161.40	OUTPATIENT SPEECH PATHOLOGY			N		N	
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N				165.00	
		Name		County		State	
		0		1.00		2.00	
						3.00	
						4.00	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y				167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1332	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/15/2018 9:35 am	
			Beginning 1.00	Ending 2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		07/01/2017	06/30/2018	170.00
			1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1332	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/15/2018 9:35 am		
			Y/N	Date		
			1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.						
COMPLETED BY ALL HOSPITALS						
Provider Organization and Operation						
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00	
			Y/N	Date	V/I	
			1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00	
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00	
			Y/N	Type	Date	
			1.00	2.00	3.00	
Financial Data and Reports						
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00	
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			5.00	
			Y/N	Legal Oper.		
			1.00	2.00		
Approved Educational Activities						
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00	
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00	
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00	
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00	
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00	
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00	
			Y/N			
			1.00			
Bad Debts						
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00	
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			Y	13.00	
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00	
Bed Complement						
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00	
			Part A		Part B	
			Y/N	Date	Y/N	Date
			1.00	2.00	3.00	4.00
PS&R Data						
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N		
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	09/05/2018	Y	09/05/2018	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1332	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/15/2018 9:35 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		Y		35.00
			Y/N	Date	
			1.00	2.00	
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAVID		GOODMAN	41.00
42.00	Enter the employer/company name of the cost report preparer.	WI PFLI LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	6082702962		DGOODMAN@WI PFLI . COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1332	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/15/2018 9:35 am
		3.00		
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CPA		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/15/2018 9:35 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	20,352.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	20,352.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	20,352.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/15/2018 9:35 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	640	36	848			1.00
2.00 HMO and other (see instructions)	46	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	1,615	0	1,647			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	2,255	36	2,495			7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	2,255	36	2,495	0.00	138.86	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	138.86	27.00
28.00 Observation Bed Days		0	429			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00
33.01 LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/15/2018 9:35 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	185	17	255	1.00
2.00 HMO and other (see instructions)				14	0		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0	185	17		255	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
25.10 CMHC - CORF	0.00						25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0.00						25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00						25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00						25.40
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days				0			33.00
33.01 LTCH site neutral days and discharges				0			33.01

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet S-7

Date/Time Prepared:  
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		1.00	2.00		
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	04/01/2004		2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	3.00
4.00		RUL	0	0	4.00
5.00		RVX	0	0	5.00
6.00		RVL	0	0	6.00
7.00		RHX	0	0	7.00
8.00		RHL	0	0	8.00
9.00		RMX	0	0	9.00
10.00		RML	0	0	10.00
11.00		RLX	0	0	11.00
12.00		RUC	0	0	12.00
13.00		RUB	0	0	13.00
14.00		RUA	0	0	14.00
15.00		RVC	0	0	15.00
16.00		RVB	0	0	16.00
17.00		RVA	0	0	17.00
18.00		RHC	0	0	18.00
19.00		RHB	0	0	19.00
20.00		RHA	0	0	20.00
21.00		RMC	0	0	21.00
22.00		RMB	0	0	22.00
23.00		RMA	0	0	23.00
24.00		RLB	0	0	24.00
25.00		RLA	0	0	25.00
26.00		ES3	0	0	26.00
27.00		ES2	0	0	27.00
28.00		ES1	0	0	28.00
29.00		HE2	0	0	29.00
30.00		HE1	0	0	30.00
31.00		HD2	0	0	31.00
32.00		HD1	0	0	32.00
33.00		HC2	0	0	33.00
34.00		HC1	0	0	34.00
35.00		HB2	0	0	35.00
36.00		HB1	0	0	36.00
37.00		LE2	0	0	37.00
38.00		LE1	0	0	38.00
39.00		LD2	0	0	39.00
40.00		LD1	0	0	40.00
41.00		LC2	0	0	41.00
42.00		LC1	0	0	42.00
43.00		LB2	0	0	43.00
44.00		LB1	0	0	44.00
45.00		CE2	0	0	45.00
46.00		CE1	0	0	46.00
47.00		CD2	0	0	47.00
48.00		CD1	0	0	48.00
49.00		CC2	0	0	49.00
50.00		CC1	0	0	50.00
51.00		CB2	0	0	51.00
52.00		CB1	0	0	52.00
53.00		CA2	0	0	53.00
54.00		CA1	0	0	54.00
55.00		SE3	0	0	55.00
56.00		SE2	0	0	56.00
57.00		SE1	0	0	57.00
58.00		SSC	0	0	58.00
59.00		SSB	0	0	59.00
60.00		SSA	0	0	60.00
61.00		IB2	0	0	61.00
62.00		IB1	0	0	62.00
63.00		IA2	0	0	63.00
64.00		IA1	0	0	64.00
65.00		BB2	0	0	65.00
66.00		BB1	0	0	66.00
67.00		BA2	0	0	67.00
68.00		BA1	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet S-7

Date/Time Prepared:  
11/15/2018 9:35 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	0	0	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)
		1.00	2.00

201.00 SNF SERVICES  
 Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable). 201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?
		1.00	2.00	3.00

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

202.00	Staffing	0	0.00	202.00
203.00	Recruitment	0	0.00	203.00
204.00	Retention of employees	0	0.00	204.00
205.00	Training	0	0.00	205.00
206.00	OTHER (SPECIFY)	0	0.00	206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	0		207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-1332	Period: From 07/01/2017 To 06/30/2018	Worksheet S-10 Date/Time Prepared: 11/15/2018 9:35 am
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			1.00		
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.404022	1.00	
<b>Medicaid (see instructions for each line)</b>					
2.00	Net revenue from Medicaid		3,127,923	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		7,692,317	6.00	
7.00	Medicaid cost (line 1 times line 6)		3,107,865	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00	
<b>Children's Health Insurance Program (CHIP) (see instructions for each line)</b>					
9.00	Net revenue from stand-alone CHIP		0	9.00	
10.00	Stand-alone CHIP charges		0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
<b>Other state or local government indigent care program (see instructions for each line)</b>					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
<b>Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)</b>					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00	
			Uninsured patients	Insured patients	Total (col. 1 + col. 2)
			1.00	2.00	3.00
<b>Uncompensated Care (see instructions for each line)</b>					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	970,097	0	970,097	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	391,941	0	391,941	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	391,941	0	391,941	23.00
			1.00		
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			1,084,619	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			212,212	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			326,480	27.01
28.00	Non-Medicare bad debt expense (see instructions)			758,139	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			420,573	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			812,514	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			812,514	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1332

Period: From 07/01/2017 To 06/30/2018

Worksheet A  
Date/Time Prepared: 11/15/2018 9:35 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100		703,606	703,606	-123,327	580,279	1.00
2.00	00200		812,791	812,791	9,911	822,702	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	95,139	2,446,533	2,541,672	0	2,541,672	4.00
5.01	00592	927,637	2,111,493	3,039,130	-46,205	2,992,925	5.01
6.00	00600	0	0	0	0	0	6.00
7.00	00700	230,215	441,288	671,503	0	671,503	7.00
8.00	00800	35,339	54,107	89,446	0	89,446	8.00
9.00	00900	129,557	24,112	153,669	0	153,669	9.00
10.00	01000	139,458	136,288	275,746	0	275,746	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	515,098	17,436	532,534	0	532,534	13.00
14.00	01400	0	0	0	0	0	14.00
14.01	01401	0	0	0	0	0	14.01
14.02	01402	43,461	4,419	47,880	0	47,880	14.02
15.00	01500	0	1,005,226	1,005,226	-604,753	400,473	15.00
16.00	01600	180,244	78,257	258,501	0	258,501	16.00
17.00	01700	0	710	710	0	710	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	1,173,640	163,917	1,337,557	-61	1,337,496	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	567,965	402,622	970,587	6,509	977,096	50.00
53.00	05300	0	160,725	160,725	-50,748	109,977	53.00
54.00	05400	457,159	322,110	779,269	0	779,269	54.00
54.01	03040	0	212,107	212,107	0	212,107	54.01
56.00	05600	84,524	377,139	461,663	0	461,663	56.00
60.00	06000	571,531	648,687	1,220,218	0	1,220,218	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	132,800	36,444	169,244	-16,642	152,602	65.00
65.50	06501	41,734	73,557	115,291	0	115,291	65.50
66.00	06600	1,058,467	130,042	1,188,509	0	1,188,509	66.00
67.00	06700	135,059	5,710	140,769	0	140,769	67.00
69.00	06900	0	72,275	72,275	0	72,275	69.00
71.00	07100	0	34,889	34,889	63,627	98,516	71.00
73.00	07300	0	0	0	602,322	602,322	73.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	757,406	2,118,785	2,876,191	-254	2,875,937	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		7,276,433	12,595,275	19,871,708	-159,621	19,712,087	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.02	19201	727,145	460,992	1,188,137	159,621	1,347,758	192.02
192.03	19202	0	0	0	0	0	192.03
200.00		8,003,578	13,056,267	21,059,845	0	21,059,845	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet A  
Date/Time Prepared:  
11/15/2018 9:35 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-126,417	453,862	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-16,049	806,653	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-747	2,540,925	4.00
5.01	00592	ADMINISTRATION & GENERAL	-635,629	2,357,296	5.01
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	671,503	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	89,446	8.00
9.00	00900	HOUSEKEEPING	0	153,669	9.00
10.00	01000	DIETARY	-45,874	229,872	10.00
11.00	01100	CAFETERIA	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	532,534	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
14.01	01401	PURCHASING	0	0	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	0	47,880	14.02
15.00	01500	PHARMACY	0	400,473	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,155	254,346	16.00
17.00	01700	SOCIAL SERVICE	0	710	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECFY)	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	0	1,337,496	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	977,096	50.00
53.00	05300	ANESTHESIOLOGY	-90,234	19,743	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-144	779,125	54.00
54.01	03040	ULTRA SOUND	0	212,107	54.01
56.00	05600	RADIOISOTOPE	0	461,663	56.00
60.00	06000	LABORATORY	-40,730	1,179,488	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	152,602	65.00
65.50	06501	SLEEP LAB	-18,225	97,066	65.50
66.00	06600	PHYSICAL THERAPY	-70,274	1,118,235	66.00
67.00	06700	OCCUPATIONAL THERAPY	-20,255	120,514	67.00
69.00	06900	ELECTROCARDIOLOGY	-36,955	35,320	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	-777	97,739	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	602,322	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100	EMERGENCY	-1,195,082	1,680,855	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,301,547	17,410,540	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
192.02	19201	ASSISTED LIVING	-106	1,347,652	192.02
192.03	19202	CARDIAC REHAB	0	0	192.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,301,653	18,758,192	200.00

		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
<b>A - TO RECLASS DRUG COST FROM PHARMACY</b>						
1.00	DRUGS CHARGED TO PATIENTS		73.00	0	602,322	1.00
	TOTALS			0	602,322	
<b>B - TO RECLASS MED SUPPLY FROM PHARMACY</b>						
1.00	MEDICAL SUPPLIES CHARGED TO PAT		71.00	0	1,128	1.00
	TOTALS			0	1,128	
<b>C - TO RECLASS MED SUPPLY FROM OR</b>						
1.00	MEDICAL SUPPLIES CHARGED TO PAT		71.00	0	43,144	1.00
	TOTALS			0	43,144	
<b>D - TO RECLASS OXGEN FROM RT TO MED SUP</b>						
1.00	MEDICAL SUPPLIES CHARGED TO PAT		71.00	0	16,642	1.00
	TOTALS			0	16,642	
<b>E - TO RECLASS INSURANCE</b>						
1.00	CAP REL COSTS-BLDG & FIXT		1.00	0	18,020	1.00
2.00	CAP REL COSTS-MVBLE EQUIP		2.00	0	28,185	2.00
	TOTALS			0	46,205	
<b>F - TO RECLASS DEPRECIATION</b>						
1.00	ASSISTED LIVING		192.02	0	159,621	1.00
2.00			0.00	0	0	2.00
	TOTALS			0	159,621	
<b>G - TO RECLASS ONCALL EXPENSE</b>						
1.00	OPERATING ROOM		50.00	0	50,676	1.00
	TOTALS			0	50,676	
<b>H - TO RECLASS IV THERAPY TO MED SUP</b>						
1.00	MEDICAL SUPPLIES CHARGED TO PAT		71.00	0	2,713	1.00
2.00			0.00	0	0	2.00
3.00			0.00	0	0	3.00
4.00			0.00	0	0	4.00
5.00			0.00	0	0	5.00
	TOTALS			0	2,713	
500.00	Grand Total: Increases			0	922,451	500.00

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
<b>A - TO RECLASS DRUG COST FROM PHARMACY</b>							
1.00	PHARMACY	15.00	0	602,322	0		1.00
	TOTALS		0	602,322			
<b>B - TO RECLASS MED SUPPLY FROM PHARMACY</b>							
1.00	PHARMACY	15.00	0	1,128	0		1.00
	TOTALS		0	1,128			
<b>C - TO RECLASS MED SUPPLY FROM OR</b>							
1.00	OPERATING ROOM	50.00	0	43,144	0		1.00
	TOTALS		0	43,144			
<b>D - TO RECLASS OXGEN FROM RT TO MED SUP</b>							
1.00	RESPIRATORY THERAPY	65.00	0	16,642	0		1.00
	TOTALS		0	16,642			
<b>E - TO RECLASS INSURANCE</b>							
1.00	ADMINISTRATION & GENERAL	5.01	0	46,205	12		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	46,205			
<b>F - TO RECLASS DEPRECIATION</b>							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	141,347	9		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	18,274	9		2.00
	TOTALS		0	159,621			
<b>G - TO RECLASS ONCALL EXPENSE</b>							
1.00	ANESTHESIOLOGY	53.00	0	50,676	0		1.00
	TOTALS		0	50,676			
<b>H - TO RECLASS IV THERAPY TO MED SUP</b>							
1.00	PHARMACY	15.00	0	1,303	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	61	0		2.00
3.00	OPERATING ROOM	50.00	0	1,023	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	72	0		4.00
5.00	EMERGENCY	91.00	0	254	0		5.00
	TOTALS		0	2,713			
500.00	Grand Total: Decreases		0	922,451			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet A-7  
Part I  
Date/Time Prepared:  
11/15/2018 9:35 am

		Acquisitions			Disposals and Retirements		
		Beginning Balances	Purchases	Donation			Total
		1.00	2.00	3.00			4.00
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	295,110	0	0	0	1.00	
2.00	Land Improvements	1,687,647	71,415	0	71,415	2.00	
3.00	Buildings and Fixtures	16,541,079	233,724	0	233,724	3.00	
4.00	Building Improvements	0	0	0	0	4.00	
5.00	Fixed Equipment	164,333	0	0	0	5.00	
6.00	Movable Equipment	12,593,689	537,373	0	537,373	6.00	
7.00	HIT designated Assets	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	31,281,858	842,512	0	842,512	8.00	
9.00	Reconciling Items	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	31,281,858	842,512	0	842,512	10.00	
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	295,110	0			1.00	
2.00	Land Improvements	1,759,062	0			2.00	
3.00	Buildings and Fixtures	16,740,035	0			3.00	
4.00	Building Improvements	0	0			4.00	
5.00	Fixed Equipment	164,333	0			5.00	
6.00	Movable Equipment	13,131,062	0			6.00	
7.00	HIT designated Assets	0	0			7.00	
8.00	Subtotal (sum of lines 1-7)	32,089,602	0			8.00	
9.00	Reconciling Items	0	0			9.00	
10.00	Total (line 8 minus line 9)	32,089,602	0			10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet A-7  
Part II  
Date/Time Prepared:  
11/15/2018 9:35 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	703,606	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	812,791	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,516,397	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	703,606				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	812,791				2.00
3.00	Total (sum of lines 1-2)	0	1,516,397				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet A-7  
Part III  
Date/Time Prepared:  
11/15/2018 9:35 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	18,663,430	0	18,663,430	0.587002	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	13,131,061	0	13,131,061	0.412998	0	2.00
3.00	Total (sum of lines 1-2)	31,794,491	0	31,794,491	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	435,842	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	778,468	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,214,310	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	18,020	0	0	453,862	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	28,185	0	0	806,653	2.00
3.00	Total (sum of lines 1-2)	0	46,205	0	0	1,260,515	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-200,072	CAP REL COSTS-BLDG & FIXT	1.00		9	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)		0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-4,456	ADMINISTRATION & GENERAL	5.01		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)	B	-7,111	ADMINISTRATION & GENERAL	5.01		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-315	ADMINISTRATION & GENERAL	5.01		0	7.00
8.00 Television and radio service (chapter 21)		0		0.00		0	8.00
9.00 Parking lot (chapter 21)		0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-1,290,992				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00		0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0				0	12.00
13.00 Laundry and linen service		0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-40,958	DIETARY	10.00		0	14.00
15.00 Rental of quarters to employees and others		0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients	B	-777	MEDICAL SUPPLIES CHARGED TO PAT	71.00		0	16.00
17.00 Sale of drugs to other than patients		0		0.00		0	17.00
18.00 Sale of medical records and abstracts	B	-4,155	MEDICAL RECORDS & LIBRARY	16.00		0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00		0	19.00
20.00 Vending machines	B	-3	DIETARY	10.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00			28.00
29.00 Physicians' assistant		0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00			30.99

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.	
			Cost Center	Line #			
			1.00	2.00	3.00		4.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***			68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-16,049	CAP REL COSTS-MVBLE EQUIP	2.00		9	32.00
33.00 NUTRITIONAL SERVICES	A	-4,913	DIETARY	10.00		0	33.00
34.00 CRNA	A	-90,234	ANESTHESIOLOGY	53.00		0	34.00
35.00 LOBBYING PORTION OF DUES	A	-10,968	ADMINISTRATION & GENERAL	5.01		0	35.00
36.00 MARKETING COSTS	A	-76,236	ADMINISTRATION & GENERAL	5.01		0	36.00
40.00 OTHER ADJUSTMENTS (SPECIFY (3))		0		0.00		0	40.00
41.00 EMPLOYEE MEALS - ALF	B	-106	ASSISTED LIVING	192.02		0	41.00
42.00 OTHER MISCELLANEOUS	B	-144	RADIOLOGY-DIAGNOSTIC	54.00		0	42.00
43.00 ALCOHOLIC BEVERAGES	A	-747	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	43.00
44.00 DIAMOND CLUB FEES	B	-8,832	ADMINISTRATION & GENERAL	5.01		0	44.00
45.00 DAYCARE REVENUE	B	-2,347	ADMINISTRATION & GENERAL	5.01		0	45.00
45.01 AMBULANCE RECEIPTS	B	-6,209	ADMINISTRATION & GENERAL	5.01		0	45.01
45.05 MEDICAID TAX ASSESSMENT	A	-358,949	ADMINISTRATION & GENERAL	5.01		0	45.05
45.06 RETIREMENT OBLIGATION	A	-1,692	CAP REL COSTS-BLDG & FIXT	1.00		9	45.06
45.07 DONATIONS	A	-3,693	ADMINISTRATION & GENERAL	5.01		0	45.07
45.48 PHYSICAL THERAPY DONATIONS	A	-700	PHYSICAL THERAPY	66.00		0	45.48
45.49 PHYSICIAN RECRUITMENT	A	-125,026	ADMINISTRATION & GENERAL	5.01		0	45.49
45.50 LAND RENTAL TO HILLSBORO AREA HEALTH	A	-41	ADMINISTRATION & GENERAL	5.01		0	45.50
47.00 CASH OVER	B	-16	ADMINISTRATION & GENERAL	5.01		0	47.00
47.01 PHYSICAL THERAPY STAFF REVENUE	B	-69,574	PHYSICAL THERAPY	66.00		0	47.01
47.02 OCCUPATIONAL THERAPY STAFF REVENUE	B	-20,255	OCCUPATIONAL THERAPY	67.00		0	47.02
47.03 STUDENT EDUCATION REIMBURSEMENT	A	-31,430	ADMINISTRATION & GENERAL	5.01		0	47.03
47.04 HSHS MEDICAL GROUP RENTAL SPACE DT	A	-1,640	CAP REL COSTS-BLDG & FIXT	1.00		9	47.04
47.05 ACCRETION EXPENSE - CREDIT ADD BACK	A	1,607	CAP REL COSTS-BLDG & FIXT	1.00		9	47.05
47.06 ARO LIABILITY - ABATEMENT PAID IN CY	A	75,380	CAP REL COSTS-BLDG & FIXT	1.00		9	47.06
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,301,653					50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.  
 (2) Basis for adjustment (see instructions).  
 A. Costs - if cost, including applicable overhead, can be determined.  
 B. Amount Received - if cost cannot be determined.  
 (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.  
 Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS  
 Provider CCN: 14-1332  
 Period: From 07/01/2017 To 06/30/2018  
 Worksheet A-8-1  
 Date/Time Prepared: 11/15/2018 9:35 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	66.00	PHYSICAL THERAPY	RENT	40,004	40,004 1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	WELLNESS BENEFIT	125,000	125,000 2.00
3.00	0.00			0	0 3.00
4.00	0.00			0	0 4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			165,004	165,004 5.00

\* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	G	HI LLSBORO HEALTH SERVICES	0.00	HI LLSBORO HEALTH SERVICES	0.00	6.00
7.00	G	HI LLSBORO HEALTH SERVICES	0.00	HI LLSBORO HEALTH SERVICES	0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet A-8-1

Date/Time Prepared:  
11/15/2018 9:35 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	0	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	0	0		5.00

\* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Related Organization(s) and/or Home Office	Type of Business		
	6.00		
<b>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>			

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	HEALTH RELATED SERVICES		6.00
7.00	HEALTH RELATED SERVICES		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet A-8-2

Date/Time Prepared:  
11/15/2018 9:35 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	92,650	40,730	51,920	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	36,955	36,955	0	0	0	2.00
3.00	91.00	EMERGENCY	1,840,287	1,195,082	645,205	0	0	3.00
4.00	65.50	SLEEP LAB	18,225	18,225	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,988,117	1,290,992	697,125	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	65.50	SLEEP LAB	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	40,730		1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	36,955		2.00
3.00	91.00	EMERGENCY	0	0	0	1,195,082		3.00
4.00	65.50	SLEEP LAB	0	0	0	18,225		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,290,992		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1332

Period: 07/01/2017 To 06/30/2018

Worksheet B Part I Date/Time Prepared: 11/15/2018 9:35 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	453,862	453,862			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	806,653		806,653		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,540,925	1,687	2,999	2,545,611	4.00
5.01 00592	ADMINISTRATION & GENERAL	2,357,296	134,916	239,788	293,968	5.01
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	671,503	35,678	63,411	74,255	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	89,446	12,884	22,898	11,399	8.00
9.00 00900	HOUSEKEEPING	153,669	1,774	3,153	41,788	9.00
10.00 01000	DIETARY	229,872	19,105	33,955	44,982	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	532,534	13,362	23,748	166,144	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
14.01 01401	PURCHASING	0	0	0	0	14.01
14.02 01402	CENTRAL SERVICES & SUPPLY	47,880	5,473	9,728	14,018	14.02
15.00 01500	PHARMACY	400,473	3,084	5,482	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	254,346	11,712	20,817	58,137	16.00
17.00 01700	SOCIAL SERVICE	710	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	1,337,496	64,365	114,396	378,556	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	977,096	38,722	68,821	183,196	50.00
53.00 05300	ANESTHESIOLOGY	19,743	363	645	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	779,125	21,583	38,360	147,456	54.00
54.01 03040	ULTRA SOUND	212,107	1,337	2,375	0	54.01
56.00 05600	RADIOISOTOPE	461,663	6,314	11,222	27,263	56.00
60.00 06000	LABORATORY	1,179,488	11,963	21,261	184,346	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	152,602	5,411	9,616	42,834	65.00
65.50 06501	SLEEP LAB	97,066	1,693	3,010	13,461	65.50
66.00 06600	PHYSICAL THERAPY	1,118,235	28,609	50,847	341,406	66.00
67.00 06700	OCCUPATIONAL THERAPY	120,514	0	0	43,563	67.00
69.00 06900	ELECTROCARDIOLOGY	35,320	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	97,739	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	602,322	0	0	0	73.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100	EMERGENCY	1,680,855	33,827	60,121	244,300	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 09910	CORF	0	0	0	0	99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	17,410,540	453,862	806,653	2,311,072	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
192.02 19201	ASSISTED LIVING	1,347,652	0	0	234,539	192.02
192.03 19202	CARDIAC REHAB	0	0	0	0	192.03
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	18,758,192	453,862	806,653	2,545,611	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet B  
Part I  
Date/Time Prepared:  
11/15/2018 9:35 am

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.01	6.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00592	3,025,968					5.01
6.00	00600	0	0				6.00
7.00	00700	162,500	0	1,007,347			7.00
8.00	00800	26,279	0	46,091	208,997		8.00
9.00	00900	38,542	0	6,346	0	245,272	9.00
10.00	01000	63,072	0	68,347	0	17,555	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	141,523	0	47,801	0	12,278	13.00
14.00	01400	0	0	0	0	0	14.00
14.01	01401	0	0	0	0	0	14.01
14.02	01402	14,829	0	19,580	0	5,029	14.02
15.00	01500	78,675	0	11,034	0	2,834	15.00
16.00	01600	66,360	0	41,901	0	10,762	16.00
17.00	01700	137	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	364,452	0	230,264	208,997	59,147	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	243,858	0	138,527	0	35,581	50.00
53.00	05300	3,991	0	1,298	0	333	53.00
54.00	05400	189,750	0	77,214	0	19,832	54.00
54.01	03040	41,511	0	4,782	0	1,228	54.01
56.00	05600	97,414	0	22,588	0	5,802	56.00
60.00	06000	268,713	0	42,796	0	10,992	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	40,481	0	19,356	0	4,972	65.00
65.50	06501	22,164	0	6,058	0	1,556	65.50
66.00	06600	296,033	0	102,348	0	26,288	66.00
67.00	06700	31,559	0	0	0	0	67.00
69.00	06900	6,794	0	0	0	0	69.00
71.00	07100	18,799	0	0	0	0	71.00
73.00	07300	115,852	0	0	0	0	73.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	388,358	0	121,016	0	31,083	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		2,721,646	0	1,007,347	208,997	245,272	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.02	19201	304,322	0	0	0	0	192.02
192.03	19202	0	0	0	0	0	192.03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		3,025,968	0	1,007,347	208,997	245,272	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet B  
Part I  
Date/Time Prepared:  
11/15/2018 9:35 am

Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00592						5.01
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	476,888					10.00
11.00	01100	0	0				11.00
12.00	01200	0	0	0			12.00
13.00	01300	0	0	0	937,390		13.00
14.00	01400	0	0	0	0	0	14.00
14.01	01401	0	0	0	0	0	14.01
14.02	01402	0	0	0	0	0	14.02
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	476,888	0	0	567,071	0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	0	0	101,537	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	0	0	0	0	54.00
54.01	03040	0	0	0	0	0	54.01
56.00	05600	0	0	0	0	0	56.00
60.00	06000	0	0	0	102,175	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	0	0	0	23,741	0	65.00
65.50	06501	0	0	0	7,461	0	65.50
66.00	06600	0	0	0	0	0	66.00
67.00	06700	0	0	0	0	0	67.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	0	0	0	135,405	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		476,888	0	0	937,390	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.02	19201	0	0	0	0	0	192.02
192.03	19202	0	0	0	0	0	192.03
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		476,888	0	0	937,390	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet B  
Part I  
Date/Time Prepared:  
11/15/2018 9:35 am

Cost Center Description		PURCHASING	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		14.01	14.02	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00592						5.01
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
12.00	01200						12.00
13.00	01300						13.00
14.00	01400						14.00
14.01	01401	0					14.01
14.02	01402	0	116,537				14.02
15.00	01500	0	387	501,969			15.00
16.00	01600	0	324	0	464,359		16.00
17.00	01700	0	0	0	0	847	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	7,331	2,253	38,426	847	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	33,229	911	43,455	0	50.00
53.00	05300	0	1,597	595	5,856	0	53.00
54.00	05400	0	8,337	21,086	108,735	0	54.00
54.01	03040	0	1,738	0	18,035	0	54.01
56.00	05600	0	599	23,774	30,160	0	56.00
60.00	06000	0	42,436	0	66,620	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	0	0	0	3,070	0	65.00
65.50	06501	0	27	0	6,343	0	65.50
66.00	06600	0	1,693	1	38,659	0	66.00
67.00	06700	0	215	0	3,191	0	67.00
69.00	06900	0	215	0	7,165	0	69.00
71.00	07100	0	11,876	0	12,205	0	71.00
73.00	07300	0	0	451,844	25,064	0	73.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	0	6,533	1,505	57,375	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		0	116,537	501,969	464,359	847	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.02	19201	0	0	0	0	0	192.02
192.03	19202	0	0	0	0	0	192.03
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		0	116,537	501,969	464,359	847	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet B  
Part I  
Date/Time Prepared:  
11/15/2018 9:35 am

Cost Center Description	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS		PARAMED PRGM	
			SERVICES-SALARY & FRINGES A	SERVICES-OTHER PRGM COSTS A		
			19.00	20.00		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00592	ADMINISTRATION & GENERAL					5.01
6.00 00600	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
14.01 01401	PURCHASING					14.01
14.02 01402	CENTRAL SERVICES & SUPPLY					14.02
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0				19.00
20.00 02000	NURSING SCHOOL		0			20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES A			0		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS A				0	22.00
23.00 02300	PARAMED PRGM-(SPECIFY)					0 23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	0	0	0	0 30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	0	0	0	0 50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
54.01 03040	ULTRA SOUND	0	0	0	0	0 54.01
56.00 05600	RADIOISOTOPE	0	0	0	0	0 56.00
60.00 06000	LABORATORY	0	0	0	0	0 60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
65.50 06501	SLEEP LAB	0	0	0	0	0 65.50
66.00 06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0 71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99 07699	LITHOTRIpsy	0	0	0	0	0 76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100	EMERGENCY	0	0	0	0	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 09910	CORF	0	0	0	0	0 99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0 99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0 99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0 99.40
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	0 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
192.02 19201	ASSISTED LIVING	0	0	0	0	0 192.02
192.03 19202	CARDIAC REHAB	0	0	0	0	0 192.03
200.00	Cross Foot Adjustments	0	0	0	0	0 200.00
201.00	Negative Cost Centers	0	0	0	0	0 201.00
202.00	TOTAL (sum lines 118 through 201)	0	0	0	0	0 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet B  
Part I  
Date/Time Prepared:  
11/15/2018 9:35 am

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.01	00592				5.01
6.00	00600				6.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
12.00	01200				12.00
13.00	01300				13.00
14.00	01400				14.00
14.01	01401				14.01
14.02	01402				14.02
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
19.00	01900				19.00
20.00	02000				20.00
21.00	02100				21.00
22.00	02200				22.00
23.00	02300				23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	3,850,489	0	3,850,489	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	1,864,933	0	1,864,933	50.00
53.00	05300	34,421	0	34,421	53.00
54.00	05400	1,411,478	0	1,411,478	54.00
54.01	03040	283,113	0	283,113	54.01
56.00	05600	686,799	0	686,799	56.00
60.00	06000	1,930,790	0	1,930,790	60.00
62.30	06250	0	0	0	62.30
65.00	06500	302,083	0	302,083	65.00
65.50	06501	158,839	0	158,839	65.50
66.00	06600	2,004,119	0	2,004,119	66.00
67.00	06700	199,042	0	199,042	67.00
69.00	06900	49,494	0	49,494	69.00
71.00	07100	140,619	0	140,619	71.00
73.00	07300	1,195,082	0	1,195,082	73.00
76.97	07697	0	0	0	76.97
76.98	07698	0	0	0	76.98
76.99	07699	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100	2,760,378	0	2,760,378	91.00
92.00	09200		0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.10	09910	0	0	0	99.10
99.20	09920	0	0	0	99.20
99.30	09930	0	0	0	99.30
99.40	09940	0	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		16,871,679	0	16,871,679	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
192.02	19201	1,886,513	0	1,886,513	192.02
192.03	19202	0	0	0	192.03
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		18,758,192	0	18,758,192	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet B  
Part II  
Date/Time Prepared:  
11/15/2018 9:35 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,687	2,999	4,686	4,686
5.01 00592	ADMINISTRATION & GENERAL	0	134,916	239,788	374,704	541
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	0	35,678	63,411	99,089	137
8.00 00800	LAUNDRY & LINEN SERVICE	0	12,884	22,898	35,782	21
9.00 00900	HOUSEKEEPING	0	1,774	3,153	4,927	77
10.00 01000	DIETARY	0	19,105	33,955	53,060	83
11.00 01100	CAFETERIA	0	0	0	0	0
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	0	13,362	23,748	37,110	306
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
14.01 01401	PURCHASING	0	0	0	0	0
14.02 01402	CENTRAL SERVICES & SUPPLY	0	5,473	9,728	15,201	26
15.00 01500	PHARMACY	0	3,084	5,482	8,566	0
16.00 01600	MEDICAL RECORDS & LIBRARY	0	11,712	20,817	32,529	107
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00 02000	NURSING SCHOOL	0	0	0	0	0
21.00 02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	64,365	114,396	178,761	695
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	38,722	68,821	107,543	337
53.00 05300	ANESTHESIOLOGY	0	363	645	1,008	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	21,583	38,360	59,943	272
54.01 03040	ULTRA SOUND	0	1,337	2,375	3,712	0
56.00 05600	RADIOISOTOPE	0	6,314	11,222	17,536	50
60.00 06000	LABORATORY	0	11,963	21,261	33,224	339
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	0	5,411	9,616	15,027	79
65.50 06501	SLEEP LAB	0	1,693	3,010	4,703	25
66.00 06600	PHYSICAL THERAPY	0	28,609	50,847	79,456	629
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	80
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99 07699	LITHOTRIPSY	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100	EMERGENCY	0	33,827	60,121	93,948	450
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)				0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 09910	CORF	0	0	0	0	0
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	453,862	806,653	1,260,515	4,254
<b>NONREIMBURSABLE COST CENTERS</b>						
192.02 19201	ASSISTED LIVING	0	0	0	0	432
192.03 19202	CARDIAC REHAB	0	0	0	0	0
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	0	453,862	806,653	1,260,515	4,686

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet B  
Part II  
Date/Time Prepared:  
11/15/2018 9:35 am

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.01	6.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00592	ADMINISTRATION & GENERAL	375,245				5.01
6.00	00600	MAINTENANCE & REPAIRS	0	0			6.00
7.00	00700	OPERATION OF PLANT	20,151	0	119,377		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,259	0	5,462	44,524	8.00
9.00	00900	HOUSEKEEPING	4,780	0	752	0	10,536
10.00	01000	DIETARY	7,821	0	8,100	0	754
11.00	01100	CAFETERIA	0	0	0	0	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	17,550	0	5,665	0	527
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
14.01	01401	PURCHASING	0	0	0	0	0
14.02	01402	CENTRAL SERVICES & SUPPLY	1,839	0	2,320	0	216
15.00	01500	PHARMACY	9,756	0	1,308	0	122
16.00	01600	MEDICAL RECORDS & LIBRARY	8,229	0	4,966	0	462
17.00	01700	SOCIAL SERVICE	17	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0
23.00	02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	45,195	0	27,286	44,524	2,542
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	30,240	0	16,416	0	1,528
53.00	05300	ANESTHESIOLOGY	495	0	154	0	14
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,531	0	9,150	0	852
54.01	03040	ULTRA SOUND	5,148	0	567	0	53
56.00	05600	RADIOISOTOPE	12,080	0	2,677	0	249
60.00	06000	LABORATORY	33,323	0	5,072	0	472
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	5,020	0	2,294	0	214
65.50	06501	SLEEP LAB	2,748	0	718	0	67
66.00	06600	PHYSICAL THERAPY	36,711	0	12,129	0	1,129
67.00	06700	OCCUPATIONAL THERAPY	3,914	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	842	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	2,331	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	14,367	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIpsy	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	EMERGENCY	48,160	0	14,341	0	1,335
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0	0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	337,507	0	119,377	44,524	10,536
<b>NONREIMBURSABLE COST CENTERS</b>							
192.02	19201	ASSISTED LIVING	37,738	0	0	0	0
192.03	19202	CARDIAC REHAB	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	375,245	0	119,377	44,524	10,536

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet B  
Part II  
Date/Time Prepared:  
11/15/2018 9:35 am

Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00592						5.01
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	69,818					10.00
11.00	01100	0	0				11.00
12.00	01200	0	0	0			12.00
13.00	01300	0	0	0	61,158		13.00
14.00	01400	0	0	0	0	0	14.00
14.01	01401	0	0	0	0	0	14.01
14.02	01402	0	0	0	0	0	14.02
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	69,818	0	0	36,997	0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	0	0	6,625	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	0	0	0	0	54.00
54.01	03040	0	0	0	0	0	54.01
56.00	05600	0	0	0	0	0	56.00
60.00	06000	0	0	0	6,666	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	0	0	0	1,549	0	65.00
65.50	06501	0	0	0	487	0	65.50
66.00	06600	0	0	0	0	0	66.00
67.00	06700	0	0	0	0	0	67.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	0	0	0	8,834	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		69,818	0	0	61,158	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.02	19201	0	0	0	0	0	192.02
192.03	19202	0	0	0	0	0	192.03
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		69,818	0	0	61,158	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-1332	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part II Date/Time Prepared: 11/15/2018 9:35 am		
Cost Center Description			PURCHASING	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE
			14.01	14.02	15.00	16.00	17.00
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00592	ADMINISTRATION & GENERAL					5.01
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
14.01	01401	PURCHASING	0				14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	0	19,602			14.02
15.00	01500	PHARMACY	0	65	19,817		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	54	0	46,347	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0
23.00	02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	1,233	89	3,836	17
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	5,589	36	4,338	0
53.00	05300	ANESTHESIOLOGY	0	269	23	585	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,402	832	10,848	0
54.01	03040	ULTRA SOUND	0	292	0	1,800	0
56.00	05600	RADIOISOTOPE	0	101	939	3,011	0
60.00	06000	LABORATORY	0	7,138	0	6,650	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	306	0
65.50	06501	SLEEP LAB	0	5	0	633	0
66.00	06600	PHYSICAL THERAPY	0	285	0	3,859	0
67.00	06700	OCCUPATIONAL THERAPY	0	36	0	319	0
69.00	06900	ELECTROCARDIOLOGY	0	36	0	715	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,998	0	1,218	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	17,839	2,502	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	EMERGENCY	0	1,099	59	5,727	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0	0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	19,602	19,817	46,347	17
<b>NONREIMBURSABLE COST CENTERS</b>							
192.02	19201	ASSISTED LIVING	0	0	0	0	0
192.03	19202	CARDIAC REHAB	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	0	19,602	19,817	46,347	17

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet B  
Part II  
Date/Time Prepared:  
11/15/2018 9:35 am

Cost Center Description	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS		PARAMED PRGM	
			SERVICES-SALARY & FRINGES A	SERVICES-OTHER PRGM COSTS A		
			19.00	20.00		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00592	ADMINISTRATION & GENERAL					5.01
6.00 00600	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
14.01 01401	PURCHASING					14.01
14.02 01402	CENTRAL SERVICES & SUPPLY					14.02
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0				19.00
20.00 02000	NURSING SCHOOL		0			20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES A			0		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS A				0	22.00
23.00 02300	PARAMED PRGM-(SPECIFY)					0 23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS					30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM					50.00
53.00 05300	ANESTHESIOLOGY					53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC					54.00
54.01 03040	ULTRASOUND					54.01
56.00 05600	RADIOISOTOPE					56.00
60.00 06000	LABORATORY					60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65.00 06500	RESPIRATORY THERAPY					65.00
65.50 06501	SLEEP LAB					65.50
66.00 06600	PHYSICAL THERAPY					66.00
67.00 06700	OCCUPATIONAL THERAPY					67.00
69.00 06900	ELECTROCARDIOLOGY					69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT					71.00
73.00 07300	DRUGS CHARGED TO PATIENTS					73.00
76.97 07697	CARDIAC REHABILITATION					76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY					76.98
76.99 07699	LITHOTRIPSY					76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100	EMERGENCY					91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 09910	CORF					99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY					99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY					99.40
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	0 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
192.02 19201	ASSISTED LIVING					192.02
192.03 19202	CARDIAC REHAB					192.03
200.00	Cross Foot Adjustments	0	0	0	0	0 200.00
201.00	Negative Cost Centers	0	0	0	0	0 201.00
202.00	TOTAL (sum lines 118 through 201)	0	0	0	0	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet B  
Part II  
Date/Time Prepared:  
11/15/2018 9:35 am

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.01	00592				5.01
6.00	00600				6.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
12.00	01200				12.00
13.00	01300				13.00
14.00	01400				14.00
14.01	01401				14.01
14.02	01402				14.02
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
19.00	01900				19.00
20.00	02000				20.00
21.00	02100				21.00
22.00	02200				22.00
23.00	02300				23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	410,993	0	410,993	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	172,652	0	172,652	50.00
53.00	05300	2,548	0	2,548	53.00
54.00	05400	106,830	0	106,830	54.00
54.01	03040	11,572	0	11,572	54.01
56.00	05600	36,643	0	36,643	56.00
60.00	06000	92,884	0	92,884	60.00
62.30	06250	0	0	0	62.30
65.00	06500	24,489	0	24,489	65.00
65.50	06501	9,386	0	9,386	65.50
66.00	06600	134,198	0	134,198	66.00
67.00	06700	4,349	0	4,349	67.00
69.00	06900	1,593	0	1,593	69.00
71.00	07100	5,547	0	5,547	71.00
73.00	07300	34,708	0	34,708	73.00
76.97	07697	0	0	0	76.97
76.98	07698	0	0	0	76.98
76.99	07699	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100	173,953	0	173,953	91.00
92.00	09200		0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.10	09910	0	0	0	99.10
99.20	09920	0	0	0	99.20
99.30	09930	0	0	0	99.30
99.40	09940	0	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		1,222,345	0	1,222,345	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
192.02	19201	38,170	0	38,170	192.02
192.03	19202	0	0	0	192.03
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		1,260,515	0	1,260,515	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet B-1

Date/Time Prepared:  
11/15/2018 9:35 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	7,504,600				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		7,504,600			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	27,901	27,901	7,892,194		4.00
5.01 00592	ADMINISTRATION & GENERAL	2,230,845	2,230,845	911,392	-3,025,968	15,732,224 5.01
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00 00700	OPERATION OF PLANT	589,933	589,933	230,215	0	844,847 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	213,033	213,033	35,339	0	136,627 8.00
9.00 00900	HOUSEKEEPING	29,333	29,333	129,557	0	200,384 9.00
10.00 01000	DIETARY	315,900	315,900	139,458	0	327,914 10.00
11.00 01100	CAFETERIA	0	0	0	0	0 11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00 01300	NURSING ADMINISTRATION	220,935	220,935	515,098	0	735,788 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0 14.00
14.01 01401	PURCHASING	0	0	0	0	0 14.01
14.02 01402	CENTRAL SERVICES & SUPPLY	90,500	90,500	43,461	0	77,099 14.02
15.00 01500	PHARMACY	51,000	51,000	0	0	409,039 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	193,665	193,665	180,244	0	345,012 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	710 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	0 20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0 22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0 23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	1,064,265	1,064,265	1,173,640	0	1,894,813 30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	640,266	640,266	567,965	0	1,267,835 50.00
53.00 05300	ANESTHESIOLOGY	6,000	6,000	0	0	20,751 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	356,879	356,879	457,159	0	986,524 54.00
54.01 03040	ULTRA SOUND	22,100	22,100	0	0	215,819 54.01
56.00 05600	RADIOISOTOPE	104,400	104,400	84,524	0	506,462 56.00
60.00 06000	LABORATORY	197,800	197,800	571,531	0	1,397,058 60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00 06500	RESPIRATORY THERAPY	89,465	89,465	132,800	0	210,463 65.00
65.50 06501	SLEEP LAB	28,000	28,000	41,734	0	115,230 65.50
66.00 06600	PHYSICAL THERAPY	473,050	473,050	1,058,467	0	1,539,097 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	135,059	0	164,077 67.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	35,320 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	97,739 71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	602,322 73.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	0 76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100	EMERGENCY	559,330	559,330	757,406	0	2,019,103 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 09910	CORF	0	0	0	0	0 99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0 99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0 99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0 99.40
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	7,504,600	7,504,600	7,165,049	-3,025,968	14,150,033 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
192.02 19201	ASSISTED LIVING	0	0	727,145	0	1,582,191 192.02
192.03 19202	CARDIAC REHAB	0	0	0	0	0 192.03
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	453,862	806,653	2,545,611		3,025,968 202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.060478	0.107488	0.322548		0.192342 203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			4,686		375,245 204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000594		0.023852 205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet B-1

Date/Time Prepared:  
11/15/2018 9:35 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATION & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
207.00   NAHE unit cost multiplier (Wkst. D, Parts III and IV)			4.00	5A.01	5.01	207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet B-1

Date/Time Prepared:  
11/15/2018 9:35 am

Cost Center Description		MAINTENANCE & REPAIRS (SQ. FEET)	OPERATION OF PLANT (SQ. FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQ. FEET)	DIETARY (PATIENT DAYS)	
		6.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00592	ADMINISTRATION & GENERAL					5.01
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
7.00	00700	OPERATION OF PLANT	0	4,655,921			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	213,033	2,924		8.00
9.00	00900	HOUSEKEEPING	0	29,333	0	4,413,555	9.00
10.00	01000	DIETARY	0	315,900	0	315,900	2,924
11.00	01100	CAFETERIA	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	220,935	0	220,935	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
14.01	01401	PURCHASING	0	0	0	0	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	0	90,500	0	90,500	14.02
15.00	01500	PHARMACY	0	51,000	0	51,000	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	193,665	0	193,665	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	22.00
23.00	02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	1,064,265	2,924	1,064,265	2,924
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	640,266	0	640,266	0
53.00	05300	ANESTHESIOLOGY	0	6,000	0	6,000	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	356,879	0	356,879	0
54.01	03040	ULTRA SOUND	0	22,100	0	22,100	0
56.00	05600	RADIOISOTOPE	0	104,400	0	104,400	0
60.00	06000	LABORATORY	0	197,800	0	197,800	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	89,465	0	89,465	0
65.50	06501	SLEEP LAB	0	28,000	0	28,000	0
66.00	06600	PHYSICAL THERAPY	0	473,050	0	473,050	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	EMERGENCY	0	559,330	0	559,330	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0	0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,655,921	2,924	4,413,555	2,924
<b>NONREIMBURSABLE COST CENTERS</b>							
192.02	19201	ASSISTED LIVING	0	0	0	0	0
192.03	19202	CARDIAC REHAB	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	1,007,347	208,997	245,272	476,888
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.216358	71.476402	0.055572	163.094391
204.00		Cost to be allocated (per Wkst. B, Part II)	0	119,377	44,524	10,536	69,818
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.025640	15.227086	0.002387	23.877565
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet B-1

Date/Time Prepared:  
11/15/2018 9:35 am

Cost Center Description		CAFETERIA (GROSS SALARIES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (NURSING SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PURCHASING (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	14.01	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00592						5.01
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	5,741,995					11.00
12.00	01200	0	0				12.00
13.00	01300	515,098	0	5,243,436			13.00
14.00	01400	0	0	0	0		14.00
14.01	01401	0	0	0	0	0	14.01
14.02	01402	43,461	0	0	0	0	14.02
15.00	01500	0	0	0	0	0	15.00
16.00	01600	180,244	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	1,173,640	0	3,172,000	0	0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	567,965	0	567,965	0	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	457,159	0	0	0	0	54.00
54.01	03040	0	0	0	0	0	54.01
56.00	05600	84,524	0	0	0	0	56.00
60.00	06000	571,531	0	571,531	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	132,800	0	132,800	0	0	65.00
65.50	06501	41,734	0	41,734	0	0	65.50
66.00	06600	1,058,467	0	0	0	0	66.00
67.00	06700	157,966	0	0	0	0	67.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	757,406	0	757,406	0	0	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		5,741,995	0	5,243,436	0	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.02	19201	0	0	0	0	0	192.02
192.03	19202	0	0	0	0	0	192.03
200.00							200.00
201.00							201.00
202.00		0	0	937,390	0	0	202.00
203.00		0.000000	0.000000	0.178774	0.000000	0.000000	203.00
204.00		0	0	61,158	0	0	204.00
205.00		0.000000	0.000000	0.011664	0.000000	0.000000	205.00
206.00							206.00
207.00							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet B-1

Date/Time Prepared:  
11/15/2018 9:35 am

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQ U.S.)	PHARMACY (COSTED REQ U.S.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		14.02	15.00	16.00	17.00	19.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00592						5.01
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
12.00	01200						12.00
13.00	01300						13.00
14.00	01400						14.00
14.01	01401						14.01
14.02	01402	905,436					14.02
15.00	01500	3,004	669,138				15.00
16.00	01600	2,517		41,759,308			16.00
17.00	01700	0	0	0	2,924		17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0		20.00
21.00	02100	0	0	0	0		21.00
22.00	02200	0	0	0	0		22.00
23.00	02300	0	0	0	0		23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	56,955	3,003	3,455,561	2,924	0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	258,175	1,214	3,907,822	0	0	50.00
53.00	05300	12,407	793	526,627	0	0	53.00
54.00	05400	64,776	28,108	9,778,707	0	0	54.00
54.01	03040	13,501	0	1,621,891	0	0	54.01
56.00	05600	4,656	31,691	2,712,251	0	0	56.00
60.00	06000	329,712	0	5,990,988	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	0	0	276,115	0	0	65.00
65.50	06501	210	0	570,395	0	0	65.50
66.00	06600	13,152	1	3,476,535	0	0	66.00
67.00	06700	1,668	0	287,003	0	0	67.00
69.00	06900	1,674	0	644,350	0	0	69.00
71.00	07100	92,269	0	1,097,529	0	0	71.00
73.00	07300	0	602,322	2,253,934	0	0	73.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	50,760	2,006	5,159,600	0	0	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		905,436	669,138	41,759,308	2,924	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.02	19201	0	0	0	0	0	192.02
192.03	19202	0	0	0	0	0	192.03
200.00							200.00
201.00							201.00
202.00		116,537	501,969	464,359	847	0	202.00
203.00		0.128708	0.750173	0.011120	0.289672	0.000000	203.00
204.00		19,602	19,817	46,347	17	0	204.00
205.00		0.021649	0.029616	0.001110	0.005814	0.000000	205.00
206.00							206.00
207.00							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet B-1

Date/Time Prepared:  
11/15/2018 9:35 am

Cost Center Description	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		PARAMED PRGM (ASSIGNED TIME)		
		SERVICES-SALARY & FRINGES A (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS A (ASSIGNED TIME)			
		20.00	21.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00592	ADMINISTRATION & GENERAL					5.01
6.00 00600	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
14.01 01401	PURCHASING					14.01
14.02 01402	CENTRAL SERVICES & SUPPLY					14.02
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00 02000	NURSING SCHOOL	0				20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES A		0			21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS A			0		22.00
23.00 02300	PARAMED PRGM-(SPECIFY)				0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	0	0	0	50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01 03040	ULTRA SOUND	0	0	0	0	54.01
56.00 05600	RADIOISOTOPE	0	0	0	0	56.00
60.00 06000	LABORATORY	0	0	0	0	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	65.00
65.50 06501	SLEEP LAB	0	0	0	0	65.50
66.00 06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99 07699	LITHOTRIpsy	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100	EMERGENCY	0	0	0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 09910	CORF	0	0	0	0	99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
192.02 19201	ASSISTED LIVING	0	0	0	0	192.02
192.03 19202	CARDIAC REHAB	0	0	0	0	192.03
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	0	0	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	0.000000	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	0	0	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.000000	0.000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)	0			0	206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		PARAMED PRGM (ASSIGNED TIME)		
		SERVICES-SALARY & FRINGES A (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS A (ASSIGNED TIME)			
		20.00	21.00			
207.00   NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0.000000			0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet C  
Part I  
Date/Time Prepared:  
11/15/2018 9:35 am

		Title XVIII		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00		4.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	3,850,489		3,850,489	0	0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	1,864,933		1,864,933	0	0	50.00
53.00	05300 ANESTHESIOLOGY	34,421		34,421	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,411,478		1,411,478	0	0	54.00
54.01	03040 ULTRASOUND	283,113		283,113	0	0	54.01
56.00	05600 RADIOISOTOPE	686,799		686,799	0	0	56.00
60.00	06000 LABORATORY	1,930,790		1,930,790	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	302,083	0	302,083	0	0	65.00
65.50	06501 SLEEP LAB	158,839	0	158,839	0	0	65.50
66.00	06600 PHYSICAL THERAPY	2,004,119	0	2,004,119	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	199,042	0	199,042	0	0	67.00
69.00	06900 ELECTROCARDIOLOGY	49,494		49,494	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	140,619		140,619	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,195,082		1,195,082	0	0	73.00
76.97	07697 CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699 LI THOTRI PSY	0		0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100 EMERGENCY	2,760,378		2,760,378	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	564,929		564,929	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910 CORF	0		0	0	0	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0		0	0	0	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0		0	0	0	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0		0	0	0	99.40
200.00	Subtotal (see instructions)	17,436,608	0	17,436,608	0	0	200.00
201.00	Less Observation Beds	564,929		564,929	0	0	201.00
202.00	Total (see instructions)	16,871,679	0	16,871,679	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-1332	Period: From 07/01/2017 To 06/30/2018	Worksheet C Part I Date/Time Prepared: 11/15/2018 9:35 am
		Title XVIII	Hospital	Cost

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	2,421,980		2,421,980			30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	23,739	3,884,083	3,907,822	0.477231	0.000000	50.00
53.00 05300 ANESTHESIOLOGY	4,229	522,398	526,627	0.065361	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	186,135	9,592,572	9,778,707	0.144342	0.000000	54.00
54.01 03040 ULTRA SOUND	98,600	1,523,291	1,621,891	0.174557	0.000000	54.01
56.00 05600 RADIOISOTOPE	46,318	2,665,933	2,712,251	0.253221	0.000000	56.00
60.00 06000 LABORATORY	584,074	5,406,914	5,990,988	0.322282	0.000000	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00 06500 RESPIRATORY THERAPY	52,695	223,420	276,115	1.094048	0.000000	65.00
65.50 06501 SLEEP LAB	8,919	561,476	570,395	0.278472	0.000000	65.50
66.00 06600 PHYSICAL THERAPY	490,320	2,986,215	3,476,535	0.576470	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	150,661	136,342	287,003	0.693519	0.000000	67.00
69.00 06900 ELECTROCARDIOLOGY	26,582	617,768	644,350	0.076812	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	324,912	772,617	1,097,529	0.128123	0.000000	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	505,046	1,748,888	2,253,934	0.530220	0.000000	73.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99 07699 LI THOTRI PSY	0	0	0	0.000000	0.000000	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 09100 EMERGENCY	350	5,159,250	5,159,600	0.534998	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	126,070	907,511	1,033,581	0.546574	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 09910 CORF	0	0	0			99.10
99.20 09920 OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
200.00	Subtotal (see instructions)	5,050,630	36,708,678	41,759,308		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	5,050,630	36,708,678	41,759,308		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-1332	Period: From 07/01/2017 To 06/30/2018	Worksheet C Part I Date/Time Prepared: 11/15/2018 9:35 am
		Title XVIII	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio	
		11.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000 ADULTS & PEDIATRICS		30.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000 OPERATING ROOM	0.000000	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	03040 ULTRA SOUND	0.000000	54.01
56.00	05600 RADIOISOTOPE	0.000000	56.00
60.00	06000 LABORATORY	0.000000	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
65.00	06500 RESPIRATORY THERAPY	0.000000	65.00
65.50	06501 SLEEP LAB	0.000000	65.50
66.00	06600 PHYSICAL THERAPY	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	67.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.000000	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.97	07697 CARDIAC REHABILITATION	0.000000	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	76.98
76.99	07699 LI THOTRIpsy	0.000000	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>			
91.00	09100 EMERGENCY	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
99.10	09910 CORF		99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY		99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY		99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY		99.40
200.00	Subtotal (see instructions)		200.00
201.00	Less Observation Beds		201.00
202.00	Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet C  
Part I  
Date/Time Prepared:  
11/15/2018 9:35 am

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
			1.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS	3,850,489	3,850,489	0	3,850,489	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	1,864,933	1,864,933	0	1,864,933	50.00
53.00	05300 ANESTHESIOLOGY	34,421	34,421	0	34,421	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,411,478	1,411,478	0	1,411,478	54.00
54.01	03040 ULTRA SOUND	283,113	283,113	0	283,113	54.01
56.00	05600 RADIOISOTOPE	686,799	686,799	0	686,799	56.00
60.00	06000 LABORATORY	1,930,790	1,930,790	0	1,930,790	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	302,083	302,083	0	302,083	65.00
65.50	06501 SLEEP LAB	158,839	158,839	0	158,839	65.50
66.00	06600 PHYSICAL THERAPY	2,004,119	2,004,119	0	2,004,119	66.00
67.00	06700 OCCUPATIONAL THERAPY	199,042	199,042	0	199,042	67.00
69.00	06900 ELECTROCARDIOLOGY	49,494	49,494	0	49,494	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	140,619	140,619	0	140,619	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,195,082	1,195,082	0	1,195,082	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00	09100 EMERGENCY	2,760,378	2,760,378	0	2,760,378	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	564,929	564,929	0	564,929	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	09910 CORF	0	0	0	0	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
200.00	Subtotal (see instructions)	17,436,608	17,436,608	0	17,436,608	200.00
201.00	Less Observation Beds	564,929	564,929	0	564,929	201.00
202.00	Total (see instructions)	16,871,679	16,871,679	0	16,871,679	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet C  
Part I  
Date/Time Prepared:  
11/15/2018 9:35 am

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	2,421,980		2,421,980		30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	23,739	3,884,083	3,907,822	0.477231	50.00
53.00	05300	ANESTHESIOLOGY	4,229	522,398	526,627	0.065361	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	186,135	9,592,572	9,778,707	0.144342	54.00
54.01	03040	ULTRA SOUND	98,600	1,523,291	1,621,891	0.174557	54.01
56.00	05600	RADIOISOTOPE	46,318	2,665,933	2,712,251	0.253221	56.00
60.00	06000	LABORATORY	584,074	5,406,914	5,990,988	0.322282	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	52,695	223,420	276,115	1.094048	65.00
65.50	06501	SLEEP LAB	8,919	561,476	570,395	0.278472	65.50
66.00	06600	PHYSICAL THERAPY	490,320	2,986,215	3,476,535	0.576470	66.00
67.00	06700	OCCUPATIONAL THERAPY	150,661	136,342	287,003	0.693519	67.00
69.00	06900	ELECTROCARDIOLOGY	26,582	617,768	644,350	0.076812	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	324,912	772,617	1,097,529	0.128123	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	505,046	1,748,888	2,253,934	0.530220	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	EMERGENCY	350	5,159,250	5,159,600	0.534998	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	126,070	907,511	1,033,581	0.546574	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
200.00		Subtotal (see instructions)	5,050,630	36,708,678	41,759,308		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	5,050,630	36,708,678	41,759,308		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-1332	Period: From 07/01/2017 To 06/30/2018	Worksheet C Part I Date/Time Prepared: 11/15/2018 9:35 am
Cost Center Description		PPS Inpatient Ratio 11.00	Title XIX	Hospital Cost
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000		50.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03040 ULTRA SOUND	0.000000		54.01
56.00	05600 RADIOISOTOPE	0.000000		56.00
60.00	06000 LABORATORY	0.000000		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
65.50	06501 SLEEP LAB	0.000000		65.50
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.000000		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699 LI THOTRI PSY	0.000000		76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0.000000		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10	09910 CORF			99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY			99.40
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 14-1332	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part II Date/Time Prepared: 11/15/2018 9:35 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital Cost							
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	172,652	3,907,822	0.044181	17,076	754	50.00
53.00	05300 ANESTHESIOLOGY	2,548	526,627	0.004838	2,624	13	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	106,830	9,778,707	0.010925	107,664	1,176	54.00
54.01	03040 ULTRASOUND	11,572	1,621,891	0.007135	63,626	454	54.01
56.00	05600 RADIOISOTOPE	36,643	2,712,251	0.013510	28,709	388	56.00
60.00	06000 LABORATORY	92,884	5,990,988	0.015504	277,989	4,310	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	24,489	276,115	0.088691	29,212	2,591	65.00
65.50	06501 SLEEP LAB	9,386	570,395	0.016455	0	0	65.50
66.00	06600 PHYSICAL THERAPY	134,198	3,476,535	0.038601	47,016	1,815	66.00
67.00	06700 OCCUPATIONAL THERAPY	4,349	287,003	0.015153	12,209	185	67.00
69.00	06900 ELECTROCARDIOLOGY	1,593	644,350	0.002472	15,390	38	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	5,547	1,097,529	0.005054	160,611	812	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	34,708	2,253,934	0.015399	149,181	2,297	73.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	173,953	5,159,600	0.033714	28	1	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	60,299	1,033,581	0.058340	0	0	92.00
200.00	Total (lines 50 through 199)	871,651	39,337,328		911,335	14,834	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet D  
Part IV  
Date/Time Prepared:  
11/15/2018 9:35 am

Cost Center Description		Title XVIII					Hospital		
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	Cost		
		1.00	2A	2.00	3A	3.00			
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
54.01	03040	ULTRA SOUND	0	0	0	0	0	54.01	
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00	
60.00	06000	LABORATORY	0	0	0	0	0	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00	
65.50	06501	SLEEP LAB	0	0	0	0	0	65.50	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99	
<b>OUTPATIENT SERVICE COST CENTERS</b>									
91.00	09100	EMERGENCY	0	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0	92.00	
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-1332	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/15/2018 9:35 am
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Cost Center Description		Title XVIII			Hospital	Cost		
		All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	3,907,822	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	526,627	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	9,778,707	0.000000	54.00
54.01	03040	ULTRASOUND	0	0	0	1,621,891	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	2,712,251	0.000000	56.00
60.00	06000	LABORATORY	0	0	0	5,990,988	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	276,115	0.000000	65.00
65.50	06501	SLEEP LAB	0	0	0	570,395	0.000000	65.50
66.00	06600	PHYSICAL THERAPY	0	0	0	3,476,535	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	287,003	0.000000	67.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	644,350	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	1,097,529	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,253,934	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	09100	EMERGENCY	0	0	0	5,159,600	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	1,033,581	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	39,337,328		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet D  
Part IV  
Date/Time Prepared:  
11/15/2018 9:35 am

Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 + col. 7)	Title XVIII			Hospital		
			Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Cost	
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	0.000000	17,076	0	0	0	50.00	
53.00	05300 ANESTHESIOLOGY	0.000000	2,624	0	0	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	107,664	0	0	0	54.00	
54.01	03040 ULTRASOUND	0.000000	63,626	0	0	0	54.01	
56.00	05600 RADIOISOTOPE	0.000000	28,709	0	0	0	56.00	
60.00	06000 LABORATORY	0.000000	277,989	0	0	0	60.00	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
65.00	06500 RESPIRATORY THERAPY	0.000000	29,212	0	0	0	65.00	
65.50	06501 SLEEP LAB	0.000000	0	0	0	0	65.50	
66.00	06600 PHYSICAL THERAPY	0.000000	47,016	0	0	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0.000000	12,209	0	0	0	67.00	
69.00	06900 ELECTROCARDIOLOGY	0.000000	15,390	0	0	0	69.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.000000	160,611	0	0	0	71.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	149,181	0	0	0	73.00	
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97	
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98	
76.99	07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS								
91.00	09100 EMERGENCY	0.000000	28	0	0	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0.000000	0	0	0	0	92.00	
200.00	Total (lines 50 through 199)		911,335	0	0	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1332	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/15/2018 9:35 am
Title XVIII		Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0.477231	0	1,952,090	0	0
53.00 05300 ANESTHESIOLOGY	0.065361	0	248,494	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.144342	0	3,891,868	0	0
54.01 03040 ULTRASOUND	0.174557	0	644,461	0	0
56.00 05600 RADIOISOTOPE	0.253221	0	996,075	0	0
60.00 06000 LABORATORY	0.322282	0	2,377,925	64	0
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0
65.00 06500 RESPIRATORY THERAPY	1.094048	0	92,639	0	0
65.50 06501 SLEEP LAB	0.278472	0	172,353	0	0
66.00 06600 PHYSICAL THERAPY	0.576470	0	908,960	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.693519	0	51,548	0	0
69.00 06900 ELECTROCARDIOLOGY	0.076812	0	305,463	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0.128123	0	471,037	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.530220	0	1,045,659	165	0
76.97 07697 CARDIAC REHABILITATION	0.000000	0	0	0	0
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0
76.99 07699 LI THOTRI PSY	0.000000	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00 09100 EMERGENCY	0.534998	0	2,075,020	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0.546574	0	537,665	0	0
200.00	Subtotal (see instructions)	0	15,771,257	229	0
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0	0
202.00	Net Charges (line 200 - line 201)	0	15,771,257	229	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1332	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/15/2018 9:35 am
	Title XVIII	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	931,598	0		50.00
53.00 05300 ANESTHESIOLOGY	16,242	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	561,760	0		54.00
54.01 03040 ULTRA SOUND	112,495	0		54.01
56.00 05600 RADIOISOTOPE	252,227	0		56.00
60.00 06000 LABORATORY	766,362	21		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00 06500 RESPIRATORY THERAPY	101,352	0		65.00
65.50 06501 SLEEP LAB	47,995	0		65.50
66.00 06600 PHYSICAL THERAPY	523,988	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	35,750	0		67.00
69.00 06900 ELECTROCARDIOLOGY	23,463	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	60,351	0		71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	554,429	87		73.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99 07699 LI THOTRI PSY	0	0		76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00 09100 EMERGENCY	1,110,132	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	293,874	0		92.00
200.00 Subtotal (see instructions)	5,392,018	108		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	5,392,018	108		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1332 Component CCN: 14-Z332	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/15/2018 9:35 am
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0.477231	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.065361	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.144342	0	0	0	54.00
54.01	03040	ULTRA SOUND	0.174557	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.253221	0	0	0	56.00
60.00	06000	LABORATORY	0.322282	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1.094048	0	0	0	65.00
65.50	06501	SLEEP LAB	0.278472	0	0	0	65.50
66.00	06600	PHYSICAL THERAPY	0.576470	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.693519	0	0	0	67.00
69.00	06900	ELECTROCARDIOLOGY	0.076812	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.128123	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.530220	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	09100	EMERGENCY	0.534998	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0.546574	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1332 Component CCN: 14-Z332	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/15/2018 9:35 am
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0		50.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 03040 ULTRASOUND	0	0		54.01
56.00 05600 RADIOISOTOPE	0	0		56.00
60.00 06000 LABORATORY	0	0		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
65.50 06501 SLEEP LAB	0	0		65.50
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99 07699 LI THOTRI PSY	0	0		76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0	0		92.00
200.00 Subtotal (see instructions)	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1332	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/15/2018 9:35 am
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,924 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,277 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			848 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			563 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			1,084 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			640 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			562 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			1,053 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			130.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			135.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			3,850,489 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			2,168,868 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,681,621 27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			1,681,621 37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,316.86 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			842,790 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			842,790 41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-1332	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/15/2018 9:35 am
Title XVIII			Hospital		Cost
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					300,231 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,143,021 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					740,075 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					1,386,654 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					2,126,729 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					429 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,316.85 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					564,929 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1332		Period: From 07/01/2017 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/15/2018 9:35 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	410,993	3,850,489	0.106738	564,929	60,299	90.00
91.00	Nursing School cost	0	3,850,489	0.000000	564,929	0	91.00
92.00	Allied health cost	0	3,850,489	0.000000	564,929	0	92.00
93.00	All other Medical Education	0	3,850,489	0.000000	564,929	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1332	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/15/2018 9:35 am
Cost Center Description		Title XIX	Hospital	Cost
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,924 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,277 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			848 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			1,102 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			545 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			36 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		130.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		130.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,850,489	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		2,168,868	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,681,621	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,681,621	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,316.86	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		47,407	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		47,407	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-1332	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/15/2018 9:35 am
Title XIX			Hospital		Cost
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					47,407 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					429 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,316.85 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					564,929 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1332		Period: From 07/01/2017 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/15/2018 9:35 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	410,993	3,850,489	0.106738	564,929	60,299	90.00
91.00	Nursing School cost	0	3,850,489	0.000000	564,929	0	91.00
92.00	Allied health cost	0	3,850,489	0.000000	564,929	0	92.00
93.00	All other Medical Education	0	3,850,489	0.000000	564,929	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1332	Period: From 07/01/2017 To 06/30/2018	Worksheet D-3 Date/Time Prepared: 11/15/2018 9:35 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		847,330		30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.477231	17,076	8,149	50.00
53.00	05300 ANESTHESIOLOGY	0.065361	2,624	172	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.144342	107,664	15,540	54.00
54.01	03040 ULTRA SOUND	0.174557	63,626	11,106	54.01
56.00	05600 RADIOISOTOPE	0.253221	28,709	7,270	56.00
60.00	06000 LABORATORY	0.322282	277,989	89,591	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	1.094048	29,212	31,959	65.00
65.50	06501 SLEEP LAB	0.278472	0	0	65.50
66.00	06600 PHYSICAL THERAPY	0.576470	47,016	27,103	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.693519	12,209	8,467	67.00
69.00	06900 ELECTROCARDIOLOGY	0.076812	15,390	1,182	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.128123	160,611	20,578	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.530220	149,181	79,099	73.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	09100 EMERGENCY	0.534998	28	15	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0.546574	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		911,335	300,231	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		911,335		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1332 Component CCN: 14-Z332	Period: From 07/01/2017 To 06/30/2018	Worksheet D-3 Date/Time Prepared: 11/15/2018 9:35 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.477231	3,357	1,602	50.00
53.00	05300 ANESTHESIOLOGY	0.065361	525	34	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.144342	56,838	8,204	54.00
54.01	03040 ULTRA SOUND	0.174557	8,830	1,541	54.01
56.00	05600 RADIOISOTOPE	0.253221	11,041	2,796	56.00
60.00	06000 LABORATORY	0.322282	182,097	58,687	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	1.094048	12,333	13,493	65.00
65.50	06501 SLEEP LAB	0.278472	8,919	2,484	65.50
66.00	06600 PHYSICAL THERAPY	0.576470	422,954	243,820	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.693519	134,997	93,623	67.00
69.00	06900 ELECTROCARDIOLOGY	0.076812	3,380	260	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.128123	116,565	14,935	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.530220	310,136	164,440	73.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.534998	314	168	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0.546574	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,272,286	606,087	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		1,272,286		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1332	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/15/2018 9:35 am
		Title XVIII	Hospital	Cost
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		5,392,126	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		5,392,126	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		5,446,047	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		52,696	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,687,486	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,705,865	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,705,865	30.00
31.00	Primary payer payments		413	31.00
32.00	Subtotal (line 30 minus line 31)		2,705,452	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		295,924	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		192,351	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		295,924	36.00
37.00	Subtotal (see instructions)		2,897,803	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		2,897,803	40.00
40.01	Sequestration adjustment (see instructions)		57,956	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		3,241,479	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-401,632	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet E-1  
Part I  
Date/Time Prepared:  
11/15/2018 9:35 am

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		945,756		3,241,479	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	01/11/2018	41,367		0		3.01
3.02		06/13/2018	19,033		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		60,400		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,006,156		3,241,479		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		0		6.01
6.02	SETTLEMENT TO PROGRAM		20,311		401,632		6.02
7.00	Total Medicare program liability (see instructions)		985,845		2,839,847		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.		06101			8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1332

Period: From 07/01/2017

Worksheet E-1

Component CCN: 14-Z332

To 06/30/2018

Part I  
Date/Time Prepared:  
11/15/2018 9:35 am

Title XVIII

Swing Beds - SNF

Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,527,016		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	01/11/2018	117,961		0	3.01
3.02		06/13/2018	48,042		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		166,003		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,693,019		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		59,851		0	6.02
7.00	Total Medicare program liability (see instructions)		2,633,168		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.		06101		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet E-1  
Part II  
Date/Time Prepared:  
11/15/2018 9:35 am

		Title XVIII	Hospital	Cost
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
<b>INPATIENT HOSPITAL SERVICES UNDER THE IPPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 14-1332 Component CCN: 14-Z332	Period: From 07/01/2017 To 06/30/2018	Worksheet E-2 Date/Time Prepared: 11/15/2018 9:35 am
		Title XVIII	Swing Beds - SNF	Cost
		Part A	Part B	
		1.00	2.00	
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	2,147,996	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	612,148	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	1,615	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	2,760,144	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,760,144	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	2,760,144	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	73,238	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	2,686,906	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	2,686,906	0	19.00
19.01	Sequestration adjustment (see instructions)	53,738	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	2,693,019	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	-59,851	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
<b>Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment</b>				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
<b>Cost Reimbursement</b>				
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
<b>Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)</b>				
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
<b>Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement</b>				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
<b>Comparison of PPS versus Cost Reimbursement</b>				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1332	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part V Date/Time Prepared: 11/15/2018 9:35 am
		Title XVIII	Hospital	Cost
				1.00
<b>PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT</b>				
1.00	Inpatient services			1,143,021 1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			1,143,021 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1,154,451 6.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
<b>Customary charges</b>				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)			0 17.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			1,154,451 19.00
20.00	Deductibles (exclude professional component)			167,690 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			986,761 22.00
23.00	Coinurance			658 23.00
24.00	Subtotal (line 22 minus line 23)			986,103 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			30,556 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			19,861 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			30,556 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1,005,964 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 29.50
29.99	Demonstration payment adjustment amount before sequestration			0 29.99
30.00	Subtotal (see instructions)			1,005,964 30.00
30.01	Sequestration adjustment (see instructions)			20,119 30.01
30.02	Demonstration payment adjustment amount after sequestration			0 30.02
31.00	Interim payments			1,006,156 31.00
32.00	Tentative settlement (for contractor use only)			0 32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)			-20,311 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1332	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part VII Date/Time Prepared: 11/15/2018 9:35 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		47,407		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		47,407	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		47,407	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		47,407	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		47,407	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		47,407	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		47,407	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		47,407	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		47,407	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		47,407	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		47,407	0	40.00
41.00	Interim payments		47,480	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-73	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet G  
Date/Time Prepared:  
11/15/2018 9:35 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	-258,118	0	0	0	1.00
2.00	Temporary investments	19,892,266	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,871,699	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,162,296	0	0	0	6.00
7.00	Inventory	448,786	0	0	0	7.00
8.00	Prepaid expenses	374,952	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	24,167,289	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	295,110	0	0	0	12.00
13.00	Land improvements	1,687,647	0	0	0	13.00
14.00	Accumulated depreciation	-910,658	0	0	0	14.00
15.00	Buildings	16,506,311	0	0	0	15.00
16.00	Accumulated depreciation	-8,157,337	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	164,333	0	0	0	19.00
20.00	Accumulated depreciation	-161,990	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	12,593,688	0	0	0	23.00
24.00	Accumulated depreciation	-10,614,694	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	34,768	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	11,437,178	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	356,546	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	356,546	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	35,961,013	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	629,668	0	0	0	37.00
38.00	Salaries, wages, and fees payable	349,647	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	297,764	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,104,033	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,381,112	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	5,299,013	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	5,299,013	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	7,680,125	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	28,280,888				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	28,280,888	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	35,961,013	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet G-1

Date/Time Prepared:  
11/15/2018 9:35 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		25,860,016		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		1,650,713				2.00
3.00	Total (sum of line 1 and line 2)		27,510,729		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		27,510,729		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		27,510,729		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
11/15/2018 9:35 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
<b>General Inpatient Routine Services</b>					
1.00	Hospital	1,924,132		1,924,132	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,924,132		1,924,132	10.00
<b>Intensive Care Type Inpatient Hospital Services</b>					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,924,132		1,924,132	17.00
18.00	Ancillary services	2,519,574	34,941,383	37,460,957	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	ASSISTED LIVING	1,704,996	0	1,704,996	27.00
27.01	PROFESSIONAL FEES	273,978	2,303,713	2,577,691	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,422,680	37,245,096	43,667,776	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		21,059,845		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	BAD DEBT EXPENSE	1,821,663			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		1,821,663		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		22,881,508		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1332

Period:  
From 07/01/2017  
To 06/30/2018

Worksheet G-3

Date/Time Prepared:  
11/15/2018 9:35 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	43,667,776	1.00
2.00	Less contractual allowances and discounts on patients' accounts	19,658,180	2.00
3.00	Net patient revenues (line 1 minus line 2)	24,009,596	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	22,881,508	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,128,088	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	291,126	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	6,693	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	43,457	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	15,431	22.00
23.00	Governmental appropriations	0	23.00
24.00	GRANT MONEY	157,432	24.00
24.01	OTHER REVENUE	44,175	24.01
25.00	Total other income (sum of lines 6-24)	558,314	25.00
26.00	Total (line 5 plus line 25)	1,686,402	26.00
27.00	LOSS ON DISPOSAL OF ASSETS	35,689	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	35,689	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,650,713	29.00